from the IRS increased by 48.6 percent. Those applying for the earned income tax credit had a 1 in 47 chance of getting audited. Those making more than $100,000 a year had a 1 in 208 chance of getting audited. I think this is indicative and illustrates the point that the policies we are getting out of this Chamber and out of this Congress and from the President are clearly slanted towards the top 1, 2, 3, 4, 5 percent and against those people who are working poor or living in poverty.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LINDER). Without objection, the previous question is ordered on the motion to instruct.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to instruct offered by the gentleman from Ohio (Mr. RYAN).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. RYAN of Ohio. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the order of the House of earlier today, further proceedings on this motion will be postponed.

MOTION TO INSTRUCT CONFEREES ON H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

Mr. STENHOLM. Mr. Speaker, I offer a motion to instruct.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

Mr. STENHOLM moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 1 be instructed as follows:

(1) The House recede to the Senate on the provisions to guarantee access to prescription drug coverage under section 1860D–13(e) of the Social Security Act, as added by section 101(a) of the Senate amendment.

(2) To reject the provisions of section 501 of the House bill.

(3) The House recede to the Senate on the following provisions of the Senate amendment to improve rural health care:

(A) Section 403 (relating to inpatient hospital adjustment for low volume hospitals).

(B) Section 404 (relating to medicare disproportionate share adjustment for rural areas), but with the effective date applicable under section 401(b) of the House bill.

(C) Section 404A (relating to MedPAC report on medicare disproportionate share hospital adjustment payments).

(D) The following provisions of section 405 (relating to critical access hospital improvements):

(i) Subsection (a), but with the effective date applicable under section 405(f)(4) of the House bill.

(ii) Subsection (b), but with the effective date applicable under section 405(c)(2) of the House bill.

(iii) Subsections (e), (f), and (g).

(E) Section 414 (relating to rural community hospital demonstration program).

(F) Section 415 (relating to critical access hospital improvement demonstration program).

(G) Section 417 (relating to treatment of certain entities for purposes of payment under the medicare program).

(H) Section 420 (relating to conforming changes relating to Federally qualified health centers).

(I) Section 420A (relating to increase for hospitals with disproportionate indigent care revenues).

(J) Section 421 (relating to establishment of floor on geographic adjustments of payments for physicians' services).

(K) Section 425 (relating to temporary increase for ground ambulance services), but with the effective date applicable under the amendment made by section 410(2) of the House bill.

(L) Section 426 (relating to appropriate coverage of air ambulance services under ambulance fee schedule).

(M) Section 427 (relating to treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital).

(N) Section 428 (relating to improvement in rural health clinic reimbursement).

(O) Section 444 (relating to GAO study of geographic differences in payments for physicians' services).

(P) Section 450C (relating to authorization of reimbursement for all medicare part B services furnished by Indian hospitals and clinics).

(Q) Section 452 (relating to limitation on reduction in area wage adjustment factors under the prospective payment system for home health services).

(R) Section 455 (relating to MedPAC study on medicare payments and efficiencies in the health care system).

(S) Section 459 (relating to increase in medicare payment for certain home health services).

(T) Section 601 (Increase in medicaid DSH allotments for fiscal years 2004 and 2005).

(4) The House insist upon the following provisions of the House bill:

(A) Section 402 (relating to immediate establishment of uniform standardized amount in rural and small urban areas).

(B) Section 403 (relating to establishment of essential rural hospital classification).

(C) Subsections (a), (b), (d), and (e) of section 405 (relating to improvements to critical access hospital program).

(D) Section 416 (relating to revision of labor-related share of hospital inpatient pps wage index).

(E) Section 417 (relating to medicare incentive payment program improvements).

(F) Section 504 (relating to wage index classification reform).

(G) Section 601 (relating to revision of updates for physician services).

(H) Section 1001 (relating to medicaid disproportionate share hospital (DSH) payments).

Mr. STENHOLM (during the reading). Mr. Speaker, I ask unanimous consent that the motion to instruct be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

The SPEAKER pro tempore. Pursuant to clause 7 of rule XXII, the gentleman from Texas (Mr. STENHOLM) and the gentleman from Illinois (Mr. SHIMKUS) each will control 30 minutes.

The Chair recognizes the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, all of us in this body have an enormous responsibility to the American people as we put together a bill that will shape the lives of 40 million current Medicare recipients and the millions more that will be retiring in the near future. This bill will make changes that will have profound effects on all Medicare beneficiaries and particularly on the one in four who live in rural America. Rural beneficiaries have different health care needs and delivery systems than those living in urban areas and Congress has a responsibility to pass a Medicare prescription drug reform bill that is responsive to their needs.

The motion to instruct conferees that I am offering today will put the House on record in support of a conference report that addresses the unique challenges facing seniors and health care providers in rural areas as much as possible. The motion would instruct conferees to agree to the following:

Guaranteed prescription drug coverage through a Medicare fallback option in areas where private drug plans are not available.

The best provisions improving Medicare payments to health care providers in rural areas that were included in the Senate bill or the House bill.

Reject the cut in payments to hospitals in the House bill which will adversely affect hospitals in rural areas and undercut the benefits of the rural health care improvements.

Rural beneficiaries have consistently had less access to Medicare managed care plans. Since 2000, rural beneficiaries have been four times more likely than urban beneficiaries to lack a private plan option. This problem of low market penetration in rural areas by private insurance plans may be even more pronounced for a drug-only insurance plan. This motion would address this problem by calling on the conferees to accept a guaranteed fallback plan be offered through traditional Medicare that would be offered in areas where fewer than two private plans have entered to ensure that all seniors have access to this benefit.

The House bill does not include a fallback provision to ensure that seniors have prescription drug coverage in areas where private plans choose to not participate. Instead, the House bill allows the Secretary to pay the drug-only plans whatever it takes to entice them to offer plans. Because premiums for prescription drug coverage are based on what the plans are paid, plans that take the bribe to participate may have significantly higher premiums than those operating in more competitive areas. With one in four seniors residing in rural areas, it is extremely important that we not exclude rural seniors from having a prescription drug benefit, which is a very real risk if we do not provide a guaranteed fallback plan for seniors in areas where private plans are not available. To deny seniors in rural America the prescription

drug benefit option is to deny them access to quality health care.

The motion also calls on conferees to provide the strongest package possible for rural health care by taking the best of the House and Senate bills. Because of the very high proportion of elderly in rural areas, Medicare is a very large and critical source of payment for rural health care providers. Both the House and Senate bills would provide many important improvements in payments to rural health care providers. Unfortunately, there have been reports that assistance to rural health care providers is being held hostage in conference negotiations for leverage on other issues. This motion will send a clear message that the health care needs of rural America should not be used as leverage to advance an agenda on Medicare.

The House bill offers assistance to health care providers in rural areas with one hand but takes away that assistance with the other hand through a reduction in payments to hospitals, which will be particularly harmful to rural hospitals. I am sure that all of us in this body who have talked to our local hospitals as I have done have heard about the challenges that our hospitals face, higher medical malpractice premiums, an increase in the uninsured population, and uncompensated care and cutbacks at the State and local levels. Reducing payments to hospitals could jeopardize the financial life of rural providers and undercut the benefits of the rural health care improvements in the bill. The benefits of improving payments to rural health care providers and increasing access to health care in rural areas will be negated if the hospital in a rural community is forced to close its doors. We must provide equal access to care for all Medicare beneficiaries, regardless of where they live. A vote for this motion is a vote to make sure that seniors and health care providers in rural America are treated fairly by the current Medicare system and the new prescription drug benefit.

Mr. Speaker, I reserve the balance of my time.

Mr. SHIMKUS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this motion would allow the Department of Health and Human Services to offer a Medicare prescription drug plan. There is no need for this type of government-run fallback because the House-passed legislation already guarantees that every Medicare beneficiary will have a choice of at least two Medicare prescription drug plans. My colleague represents rural Texas. I represent rural Illinois. We know that one of the problems in the past was Medicare plans leaving rural areas. I think the benefit of what we have crafted is that it broadens the scope of the region, so it brings in urban and suburban and rural areas.

The motion also instructs conferees to recede to the Senate and remove the hospital market basket update adjustment contained in the House bill.

□ 1615

I would note for my colleagues that we are not cutting hospital reimbursement. We are reducing the increase they are going to receive. According to the Medicare Payment Advisory Commission, MedPAC, the nonpartisan panel of experts that advises Congress on Medicare policy, hospitals make a 10 percent profit for Medicare inpatient services and a 5 percent profit, on average, for all services provided to Medicare patients. MedPAC unanimously advised Congress to increase payments by 3 percent, which is what the House bill does. This is often referred to as market basket minus 0.4 percent.

Finally, this motion would instruct conferees to accept every rural provider increase contained in both bills. This budget-busting motion would mean the cost of the entire package would greatly exceed the $400 billion allocated under the budget resolution for Medicare prescription drugs which would jeopardize our ever getting to a final bill. Obviously, in our budget resolution we passed a bill for prescription drugs at $400 billion. If we go above that amount, we will raise to a point of order, and really we will have no resolution to this.

This motion is unnecessary. The House has already recognized the need to ensure that rural Medicare providers are paid fairly. In fact, the House-passed bill contains a $24.9 billion increase in payments to rural providers which would help rural hospitals and physicians, among others, continue to provide care to rural Americans. Let me just say that again. I traveled all through the August break to many of the rural hospitals. They do not have the numbers to be able to bring to bear all the benefits; so they really need this increase, and this rural increase of $24.9 billion is real dollars to rural hospitals, and I know my colleague knows the need for an increase in rural hospital coverage.

I would also note that conferees have reached agreement in a bipartisan, bicameral basis on a number of issues that will be reopened under this motion. Do we really want to tell the conferees to start over all from scratch? I do not because we want to see success in this Medicare prescription drug bill, and we want to finally get help to the seniors who have asked for it.

Mr. Speaker, we should allow the conferees to work out the differences between both bills. Since both Chambers have made a significant commitment on helping rural providers, I have every confidence that they will develop sound policy.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Speaker, I thank the gentleman from Texas (Mr. STENHOLM) for yielding me this time, a real hero and champion of rural health care, especially in west Texas.

Mr. Speaker, I join my colleagues in instructing the Medicare prescription drug conferees to remember our Nation's 9.3 million rural Medicare beneficiaries as they continue their critical deliberations. The way this bill currently stands is nothing more than the old bait and switch. The Republican leadership has used smoke and mirrors to trick our seniors into thinking that they are getting a Medicare prescription drug plan, when in reality they are forcing them to seek medication from private insurance companies and HMOs that will set the price and set the benefits. This HMO enrichment plan does not even pretend to address the needs of rural America.

Mr. Speaker, as my colleagues know, over 80 percent of rural health care beneficiaries today live in an area that insurance companies do not and will not serve, and it is worse than that in my district. Not one single insurance company in the United States of America has signed up for the plan that is being proposed by our friends on the other side of the aisle.

Just what has history shown us about what happens when insurance companies get involved in Medicare? Medicare+Choice, the great managed care experiment of our Nation's seniors, should have been named Medicare Minus Choice. After all it has been a total disaster. Between 1998 and 2003, the number of Medicare+Choice plans dropped in the United States by more than half. And in Texas, in our State, over 313,000 Medicare+Choice seniors have been dropped by insurance companies since 1999 alone, dropped straight in the grease in Texas because they do not want to serve rural America. Rural seniors do not have access to private insurance plans, not the same as our urban seniors, and knowing this, we must include a Government fallback option for areas served by less than two plans. And there are no plans in east Texas, no plans in rural America.

Mr. Speaker, we also need to eliminate the premium support provisions in H.R. 1 that are scheduled to take place in 2010. It is unconscionable to market this prescription drug bill as an equitable bill and universal, when these folks who stay in traditional fee-for-service Medicare will see significant premium increases under the competition program. There is no competition in rural America, and there is no service in rural America.

Rural seniors have not gotten a fair deal. On average, they are in poorer health, have lower incomes, face higher out-of-pocket medical spending than seniors in urban areas, and they are not addressed. They need our help, and yet, all we are doing with this bill is compounding the inequity rural seniors already endure.

I implore my colleagues to join me in instructing the Medicare conferees to honor our rural seniors. Rural seniors need health care. Rural seniors need our representation. The HMOs already have all that covered.

Mr. SHIMKUS. Mr. Speaker, I yield myself such time as I may consume.

Let me just respond to my colleague. The private sector already does manage the Medicare system. The private sector is already involved in Medicare. They have been doing the job now. They can do it again. If we mandate, as in our bill, that there would be two providers and, again, expand the area of coverage from cities to suburbs out to the rural areas, we will have coverage. I would remind folks $24.9 billion for rural hospitals is real money.

Mr. SANDLIN. Mr. Speaker, will the gentleman yield?

Mr. SHIMKUS. I yield to the gentleman from Texas.

Mr. SANDLIN. Mr. Speaker, how can we assume that coverage would be available in my district or in rural America when it is not available now, and countrywide it is not available in 80 percent of rural districts covered where we have Medicare-covered folks?

Mr. SHIMKUS. Mr. Speaker, reclaiming my time. Mr. Speaker, it is my time.

The SPEAKER pro tempore (Mr. LINDER). The gentleman from Illinois (Mr. SHIMKUS) controls the time.

Mr. SHIMKUS. Mr. Speaker, reclaiming my time, it is because it is on a county-by-county basis. What this Medicare bill does is set up at least at a minimum two coverage areas that would cover the cities, the suburban areas, and out to the rural areas. That way we bring in a bigger pool. But I will also say again $24.9 billion to rural hospitals we jeopardize if we go off in an opportunity to start instructing conferees and distract from this debate.

Let me say one other thing about this legislation. I know my good friends and colleagues are budget watchers, and the idea is that we have a budget that has $400 billion for prescription drug benefit coverage. Anything other than what we have going down the track would probably be risen to a point of order because what they are going to do is expand the cost structure.

Mr. Speaker, I ask unanimous consent that the gentleman from Texas (Mr. SAM JOHNSON) be allowed to control the balance of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield myself such time as I may consume.

I cannot believe we are arguing over this because there are some misnomers here, I think. When they come up with this motion to instruct, we are asking to accept the Senate's position on a government-run prescription drug delivery structure, and the CBO has estimated that that government-run provision will lead to higher prices for beneficiaries and taxpayers in over $8 billion in higher costs. That is a giveaway to the pharmaceutical industry.

This talk about seniors not having a benefit in rural areas is just not right. Both CBO and CMS agree that numerous drug plans will be available and more than 95 percent of the beneficiaries will voluntarily sign up for the benefit. These nonpartisan actuaries have no axe to grind and are in agreement on that point.

Furthermore, any action to approve the other body's position provides unprecedented inflationary increases to hospitals and other health care providers which will force the conference, as my colleague has said, to exceed the $400 billion allocation in the budget resolution, thereby jeopardizing the whole program. It will also undo bicameral, bipartisan decisions that conferees have already resolved. The motion is completely unnecessary because both bills already require prescription drug plans to assume financial risk in delivering prescription benefits to provide a fallback to guarantee all seniors have access to prescription drug plans. It does not matter whether they live in a city or in a country. Both CBO and CMS, as I said, agree that more than 95 percent of beneficiaries will voluntarily sign up.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield myself 1 minute.

To respond to my friend from Texas, this is not a budget-busting amendment. We fully expect the conferees to live within the $400 billion. We have a different idea of the prioritization than what the majority party has, and we are just expressing that today. And also, when the House has a chance to vote, Members on both sides can see whether or not the priorities we believe are the most important should be considered by the conferees. And also with the emphasis on government-run, let me remind my friend from Texas that it is only if the private system fails in rural America, will we have a return to a Medicare plan. Only if it fails. We worry because of the past history of private plans in rural America. We worry that they may not work, and we think it would be irresponsible for us not to provide a fallback. That is our opinion. It is not government- mandated, and these little speech lines that keep flowing out, this is a different idea, a different opinion, and we just expressed it today.

Mr. Speaker, I yield 4 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Texas for yielding me this time.

The premise behind the Stenholm motion is simple. One fourth of all Medicare beneficiaries live in rural areas, and they are getting the short end of the stick. Rural hospitals are closing, and there are not enough rural hospitals to begin with. Twenty-five percent, as I said, 25 percent of all Medicare beneficiaries live in rural areas; 90 percent of all physician specialists practice in urban areas. Senior and disabled Americans who need care simply are not getting it in time. That is more than a problem. It is a tragedy. Because of the high proportion of elderly in rural areas, Medicare plays a particularly important role in those areas. Inadequate Medicare reimbursement means inadequate access. There is no cushion. Our responsibility to rural Medicare enrollees is the same as our responsibility to urban Medicare enrollees. They paid in Medicare throughout their working years in exchange for health care security during their retirement. It is the covenant between the Government and its people.

Now that those people are retired, their health care should be reliable. It should be affordable. It should be easily accessible. To meet that responsibility, we need to pay rural providers enough to stay in business. It is that simple.

Unfortunately, Mr. Speaker the House bill tries to have it both ways. It invests in rural hospitals. That is good. Then it squeezes blood from them by cutting reimbursement across the board. One cannot do it both ways. It makes no sense, no sense, to undermine our own efforts to help rural providers and by extension rural beneficiaries, the whole point, by simultaneously increasing and then cutting hospital reimbursement, not to mention the negative impact on urban and suburban hospitals.

This motion, the Stenholm motion, simply instruct conferees to eliminate the hospital cut. This motion instruct conferees to ensure that no senior ends up without access to prescription drug benefits. That is what this whole exercise is all about. H.R. 1 sets the stage for two scenarios when it comes to areas traditionally underserved by HMOs. Neither of those scenarios is acceptable from a public health perspective or, as the gentleman from Texas (Mr. STENHOLM) points out, a fiscal perspective.

First, to lure an HMO to provide drug coverage in a rural or other underserved area, in a sense this Congress bribes them. Knowing the Federal Government is prepared to cover virtually all of an insurer's risk in order to attract them to a rural area, I wonder how many private plans will not hold out for this sweetheart deal? Of course they will.

□ 1630

Of course, they will. But if no plan takes the bait, then seniors in that area just do not get drug coverage.

There are many provisions in H.R. 1 and S. 1 about which Members can reasonably disagree, but do any of us really want to pass a bill that plays that kind of game? The possibility that some seniors would not have access or they will have to shower almost unlimited tax dollars on HMOs to ensure that access, why would we ever think of going down that road?

Fundamentally, the Stenholm motion instructs conferees to take the best of both bills when it comes to bolstering access to care and ensuring access to coverage in our Nation's rural

areas. It warns that the hospital cut included in H.R. 1 short-circuits the bill's provider provision, rural provider provisions, and the Federal fallback omitted from H.R. 1 is crucial if our goal truly is to fill the drug coverage gap in Medicare.

Mr. Speaker, I urge my colleagues to vote for the Stenholm motion.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am kind of getting worried about us wanting to spend more money. It seems like every time I turn around, we do that. This particular proposal spends more money. In fact, I think my colleagues forget over there that we put in $27 billion extra for rural, just for rural, and if you look at some of the statistics, Iowa, for instance, has a 5.5 percent increase and plus-up on Medicaid. I think Iowa is rural. Oklahoma has a 5.7 percent increase and a 5.9 percent increase on Medicaid. I think that is rural, for the most part.

As I go through these notes, it seems to me that the States that you call rural and are not getting anything, they are getting more. Montana gets a 5.7 increase. It is impossible for me to figure out why you think the rural areas are getting stiffed. South Dakota, 5.4 percent increase; Tennessee, 5.3 percent, and so on. I can go on and on.

But the thing is that the Senate provision, or the provision, that you are trying to affirm results in higher costs; and it is a complete and utter giveaway. I think that it is time that we got a little bit of fiscal responsibility in this House and stopped spending money.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield 3½ minutes to the gentleman from Iowa (Mr. BOSWELL).

(Mr. BOSWELL asked and was given permission to revise and extend his remarks.)

Mr. BOSWELL. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, it is my pleasure to be here. This is a very dear thing to people in my State. The gentleman made a reference to Iowa. I think if you get into the print though, you will find out that we give the 5-whatever percent, but then we take a piece of it back in the market basket thing.

So what happens here? When we are in the last position, it is a bad place to be. It is my understanding that no matter where you live, you pay the same as we go into this. We pay the same, but we do not get the same benefit.

This is doing us a lot of harm. We understand the impact this has on the older folks. Everybody thinks that just applies to them, but it applies to the whole community. When you cannot recruit doctors, you cannot retain doctors; you cannot recruit nurses, you cannot retain nurses; you cannot get technicians, you cannot retain them. You just go right on down to the mess halls, as we used to say in the Army and the Air Force. It affects the whole community, from the oldest to the youngest. You cannot buy equipment. It does not cost any less in Iowa and the rural areas than somewhere else. It is a very serious matter, and it needs attention.

So I hope that this will be accepted, that we will instruct to go and make sure that reimbursement rate is taken care of, and some equity, fairness, will take place. It is unfair discrimination, pure and simple, against States like mine, which rank last in the Nation in reimbursement, and many other areas throughout the Nation.

I find out down in Texas, there are areas out there that are as bad as we are. Yet overall, as we put all the numbers together, we go to the bottom, a rate that is less than half what the top rate is in the Nation. Something is awry. Something is wrong. We pay the same, but we cannot have the same.

Wait a minute, this is the United States of America. If we all pay the same, why do we not have the same treatment? That is not going on, and here is a chance to make that right.

So I am very hopeful, I am very hopeful, that we will not pass up this opportunity. We get to the underlying bill, the prescription drug side, that is another argument, and it affects everybody across the country. It does not affect just those of us getting a very bad shake on the reimbursement rate for Medicare. It affects everybody. I think we will keep that out in front of us for some time. I do not think that is going to go away.

But this might be the chance, this might be the chance for some parity, some equity, an opportunity to have some fairness when it comes to Medicare reimbursement.

I hope that those that have the last say on this when it comes back to us to either vote it up or vote it down will take this very, very seriously and try to treat all Americans alike. We need fairness. We pay the same, we ought to have the same result. It is a national program; it is not just for individual areas.

It is kind of interesting, I would say to the gentleman from Texas (Mr. STENHOLM), talking to you and realizing out in some of the rural areas in Texas, and I am sure it is the same in parts of your district as well, that, no, it is not so. But, anyway, it certainly is in some of the rural areas, and Texas is Texas.

Mr. Speaker, it is time for fairness. We are all Americans. We are 50 States, and we are not getting treated the same. Iowa would like to be treated as everybody else. We do not want anything extra. Just treat us the same. We stand up and pay the same; we ought to be treated the same.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I will tell you what: let us correct the record. You did get a market basket adjustment of minus 0.4 percent, but the number I quoted you was the number at the end, which was a 5.5 percent increase. That is 2.1 percent more than current law. That does not count the 5.5 percent increase in additional allotments for Medicaid. Iowa is not being mistreated. When I hear talk about let us treat everybody equal, I think of Canada and their socialist program of medicine, which has not worked; and that is why Canadians come down here for medicine.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I am just amazed when I listen to the Republican side, because they are just so bent on the ideology of this, and I think that the motion of the gentleman from Texas (Mr. STENHOLM) and what the Democrats are saying is look at this situation practically.

If you listen to what the gentleman from Texas (Mr. STENHOLM) has said in the motion to instruct, it essentially says, look, we know those of us who are in rural areas, I am not, but we know these HMOs and these private plans are not working, for the most part, and if someone tries to get their prescription drugs through an HMO or managed care private plan, in many cases it is not going to be available, and they are not going to have access to it.

It is the Republicans that basically are trying to impose an ideology and saying we must privatize, we must go this route, this is no alternative. All the gentleman from Texas (Mr. STENHOLM) is saying is in a situation where the HMOs or the private plans are not available, we still have to guarantee drug coverage for those seniors in those rural areas that cannot get it through these private HMOs or other private plans. So let us have the Senate fallback that says you can get your prescription drugs through traditional Medicare.

Now, I just do not understand why the Republicans keep insisting from an ideological point of view, well, we cannot do that; you have to privatize. They went so far as to suggest we have private contractors that provide Medicare services now, but that is the Federal Government as the ultimate insurer contract with some private company to provide the service.

What you have done in this House bill is say that if you as an individual cannot find a private plan, you are out of luck. All the gentleman from Texas (Mr. STENHOLM) is saying with this motion to instruct is let us have a fallback. Let us have an alternative for these people in rural areas when they cannot get the HMO to provide the service. What could make more sense?

Mr. Speaker, it is the same thing as far as the reimbursement rate is concerned. I heard the colleagues on the

Republican side say there is no cutback effectively in the reimbursement rate. Certainly there is. Many of us went to meet with the oncologists today, the cancer doctors; and they were talking about the negative impact on cancer victims because of this reimbursement rate. We have got to change that as well. Just follow the gentleman from Texas (Mr. STENHOLM). It is the practical way to do this, with this motion.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield 3 minutes to the gentleman from Tennessee (Mr. TANNER).

(Mr. TANNER asked and was given permission to revise and extend his remarks.)

Mr. TANNER. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, what we are talking about here is no less than a matter of life and death. All of the medical technology in the world is not going to help somebody who cannot access the system. When you are talking about Tennessee, you are talking about 47 percent of the acute care hospitals in rural Tennessee are losing money. In the House bill you cut the market basket to those hospitals.

There is no way that one can deny the fact that somebody is going to die needlessly because they do not have a hospital or an emergency medical room within 50, 60 or 70 miles, simply because they live in a rural area. You can argue about it, but there is no denying that it will happen. Somebody will die in rural America, because if this House bill goes through, you are going to see acute care hospitals in rural areas close, not to mention the fact that there are people involved.

I think my friend, the gentleman from New Jersey (Mr. PALLONE), talked about the fallback provision. Because we live in a place where you do not need a blinker signal on your car because the guy behind you knows where you are going to turn off, we do not have a lot of choice. And that is what we are talking about here. We are talking about life and death in rural America.

You may not live in rural America; but you have a cousin, an aunt or uncle, a brother, sister, or somebody that does; and these people are going to be irreversibly adversely affected if we do not accept the motion of the gentleman from Texas (Mr. STENHOLM).

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, Tennessee is kind of an interesting State, because they get a 5.3 percent increase; and it does not include six Tennessee critical access hospitals which are rural which are paid exactly what their costs are. Now, this bill is all-encompassing. It takes care of people. It does not let people die, and it does not spend the Treasury of the United States to zero.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. RODRIGUEZ).

Mr. RODRIGUEZ. Mr. Speaker, let me first of all say that what we have before us is two bills. Neither one is worth the paper they are written on, and they are not going to respond to the issues that confront us.

The approach that the gentleman from Texas (Mr. STENHOLM) is providing is to try to look at what is best and try to make something happen. The gentleman from Texas (Mr. SAM JOHNSON), I know he is from Texas also, and I am from Texas, and I have counties that right now do not have any access to any type of health care because they have chosen to leave, they were not making the profits they wanted, and we are having a rough time.

That bill is not going to be responsive. You are saying you are concerned about being fiscally responsible. My God, you are taking money from cancer, which is kind of robbing Peter to pay Paul. You are taking money from people dying from cancer to try to fill another need. We are here to tell you there are needs on both sides. That bill does not meet those needs.

So one of the things we have to come to grips with is we have a problem before us, and you are choosing not to deal with it directly, and you are choosing to play games with Americans.

Mr. SAM JOHNSON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me just make a couple of observations. The hospitals' payments include some of the payments for beneficiaries. It is not just all hospital costs. I think that we have to consider the fact that the United States Senate, which according to what this proposal embodies, puts the government fully at risk.

□ 1645

There is little incentive to control costs, and I think that the provisions have to lead to higher prices for beneficiaries and taxpayers, and it is a complete and utter giveaway. I think that we have to defeat this motion.

Mr. Speaker, I yield back the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this motion to instruct conferees is not a budget buster. It is a red herring to suggest that we are going to bust the budget at $400 million. I support that, and those of us who support this resolution support that. It is a red herring.

One of the things my friend from Texas does not seem to want to acknowledge is that there are many hospitals, as the gentleman from Iowa (Mr. BOSWELL) pointed out, there are many hospitals that have not enjoyed the increases that hospitals in the bigger towns have enjoyed over the last 20 years. And when you have not gotten the increases that some have gotten and you have gotten a lesser amount of reimbursement, you are hurting. That is why we believe the Senate provisions are fairer to those hospitals.

The gentleman is totally correct when he says they get less of an increase, no one is getting cut; but when you have a baseline that is too low, it is important that you get a chance to compete on a level playing field with those hospitals who enjoy a little better situation. We have argued for that for years, but unsuccessfully. Now we notice that there is bipartisan support for acknowledging that rural hospitals and many inner city hospitals have the same problem and that we should, in fact, recognize and begin to correct that disparity.

Regarding the pharmaceutical benefits and the going back to a government program, only if it fails will we go back to a Medicare government program. But some of us, myself included, are very skeptical that private businesses are going to be as interested in rural areas with less people as they are in urban areas; and, therefore, a fallback is critical to us. But it does not do what the gentleman said it did. It is only if it fails; only if it fails will we have a fall-back.

Now, in conclusion, it is difficult for me, and I will not miss the opportunity to say that to be lectured by my friend from Texas on fiscal responsibility, I say to the gentleman, that is a joke. For the gentleman to have supported and continue to support the economic game plan of his side of the aisle that has given us the largest deficits in the history of our country, $689 billion and going up, and I know this because my friend from Texas voted for the last bill that increased the deficit another $12 billion. I did not, and I will get criticized. But I think it is time for us to be fiscally responsible, but I find that it is only when it is convenient. If it is a tax cut, it is great. But if it is being fair to rural hospitals, that is a no-no.

As to the child tax credit, the debate that went on before this, let me point out that every single dime of tax dollars that have been collected on the Social Security system are being spent for current operating expenses. Really, we are borrowing, in addition to that, $560 billion. Differentiating between Social Security taxes and income taxes is a joke, a joke. Just because it was done for 40 years is no longer reason for us to continue to do it.

But do not lecture me on fiscal responsibility. Do not let staff feed the little notes in saying here is what it does and here is what it does not, because this motion does not bust the $400 million budget. We live within it. We only ask the conferees to make the changes. Yes, it will be difficult. Yes, you cannot do what you want to do. You cannot do the things that you want to do in total, but it is a reasonable compromise; and that is what conferences between the House and the Senate are all about. It is taking the differences and working them out in a

very, very good and concise way. But do not lecture us on budget. Go somewhere else. Argue the philosophical. That is a fair shot. The gentleman and I philosophically disagree apparently on the direction that this ought to be. That is a fair shot, and we will argue that. But this amendment does not bust the budget. It offers some, we hope, constructive suggestions; and I hope that the House will in an overwhelming vote say to the conferees, we believe this has merit, take a look at it, and let us pass it.

Mr. Speaker, this amendment is not what is important. It is what comes back, because that is what is, in fact, going to be affecting lives. And in rural areas, this is a critical difference from a hospital's standpoint. If we cannot do what this amendment does, we are going to continue to have real problems in rural areas, and anybody that represents a rural area needs to take a good hard look and hopefully join in support of this amendment.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. LINDER). Without objection, the previous question is ordered on the motion.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to instruct offered by the gentleman from Texas (Mr. STENHOLM).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. STENHOLM. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the order of the House of earlier today, further proceedings on this motion will be postponed.

MOTION TO INSTRUCT CONFEREES ON H.R. 1588, NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mr. RODRIGUEZ. Mr. Speaker, I offer a motion to instruct.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

Mr. RODRIGUEZ moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 1588 be instructed to agree to the provisions contained in subtitle F of title VI of the Senate amendment (relating to naturalization and family protection for military members).

The SPEAKER pro tempore. Pursuant to clause 7 of rule XXII, the gentleman from Texas (Mr. RODRIGUEZ) and a member from the majority party each will control 30 minutes.

The Chair recognizes the gentleman from Texas (Mr. RODRIGUEZ).

Mr. RODRIGUEZ. Mr. Speaker, I yield myself such time as I may consume.

I rise today to join my colleagues in expressing my support for the brave men and women who are risking their lives to defend our Nation. I rise to urge my colleagues to express that support by voting in favor of my motion to instruct conferees.

When hostilities broke out in Iraq, the first military member to die in combat was Marine Lance Corporal Jose Gutierrez, an immigrant from Guatemala who volunteered to serve his adopted country. He died an American hero, but he did not die an American citizen.

Lance Corporal Gutierrez was only the first of 13 noncitizen soldiers killed in Operation Iraqi Freedom. Thousands of noncitizen soldiers are currently serving in Iraq, and only 37,000 are noncitizen soldiers who serve in the Nation's Armed Forces.

The motion I am offering today expresses the continued support of the House for the Armed Forces Naturalization Act which passed, by the way, on June 4 by a vote of 414 to 5. The House has already gone on record in support of the bill to give immigrants serving in our Armed Forces more rapid naturalization and to establish protections for their families if they are killed in action.

The 37,000 immigrant soldiers have already met the same rigorous evaluation as U.S. citizens before their enlistment. In fact, the military's criteria are more challenging than the naturalization requirements demanded by the Department of Homeland Security.

Besides meeting the qualifications for military service, noncitizen soldiers have passed an even more important test: they have proven their loyalty to the United States by pledging to defend our Nation and our values with their bodies, their minds, and their lives. Their service in defense of our Nation and our country and their willingness to put their lives on the line speaks to their devotion to the United States.

Mr. Speaker, I urge my colleagues to support this small token of gratitude as a demonstration to these 37,000 Americans who are brave soldiers, to show that we appreciate their patriotism.

Mr. Speaker, I reserve the balance of my time.

Mr. SMITH of Texas. Mr. Speaker, I claim the time in opposition to the motion, and I yield myself such time as I may consume.

Mr. Speaker, this motion to instruct conferees addresses the military naturalization provisions that were included in the Department of Defense authorization bill.

On June 4, this Chamber passed H.R. 1954, the Armed Forces Naturalization Act of 2003, with overwhelming support from both sides of the aisle. This military naturalization measure has a number of good provisions. It was sent to the Senate for consideration where it was passed favorably out of the Senate Judiciary Committee. While the Senate has not taken up H.R. 1954, similar provisions were included in the Senate-passed DOD authorization bill.

The motion before us today urges conferees to adopt the provisions contained in the Senate-passed DOD authorization bill. I think this motion underscores the importance of this military naturalization legislation to both Houses and to Republicans and Democrats alike.

However, the Senate should move this bill separately rather than include it in the DOD authorization. This would give the committees with relevant jurisdiction an opportunity to fully examine the differences between the House- and the Senate-passed version and to make informed decisions about these naturalization provisions.

Most of us agree that we should expedite the naturalization process for those who have served our country and provide immigration benefits to family members of those who died. I believe H.R. 1954 accomplished those goals.

I would like to point out, however, some of the reasons why I am concerned about supporting the Senate version contained in the DOD authorization bill. First, H.R. 1954, as passed by the House, grants permanent resident status to the immediate relatives of U.S. citizen soldiers and soldiers granted posthumous citizenship if they die as a result of injuries incurred during active duty. The provisions supported by this motion to instruct conferees would only grant benefits to immediate family members if a soldier died in combat. The family of a soldier who died in training or in being transported to the front would not be granted these citizenship provisions.

Second, H.R. 1954, as passed by the House, allows the spouse of a soldier granted posthumous citizenship to immediately naturalize. This is another important provision omitted from the Senate provisions supported by this motion.

Third, H.R. 1954, as passed by the House, does not grant expedited naturalization during peacetime to a soldier who is discharged less than honorably. I do not believe we should extend the benefits of expedited naturalization to an individual discharged less than honorably, yet the Senate language does not make this distinction.

Finally, Mr. Speaker, I would like to add my concerns about the provisions that benefit illegal aliens in the Senate language supported by this motion. By contrast, H.R. 1954, as passed by the House, does not grant benefits to illegal aliens. By adopting the motion to instruct conferees, we would grant benefits to those illegal aliens, and I do not think this sets a good precedent.

I am heartened that many of us agree on providing important reforms to the naturalization process for military personnel. However, it is my hope that the Senate will take up this legislation separately so that we can resolve some important policy differences between these bills in an appropriate context.

Mr. Speaker, I reserve the balance of my time.